5. Witness Signature if Applicant/Recipient Signs with an X:





DFRAUAE01

Instructions: Complete and sign this form if you wish to authorize someone other than yourself to apply for benefits on your behalf, be interviewed on your behalf, receive copies of notices sent to you or assist you in communication with the Family and Social Services Administration (FSSA). The person you authorize to act on your behalf or receive information about your benefits must sign, date and provide their address on this form. You may authorize someone different for each benefit you are applying for or receiving and designate what activities they may complete for you. You may select an Authorized Representative for any benefit you apply for or receive. Complete the sections below to select your Authorized Representative(s). Check the box for each activity you want this person to complete for you.

Applicant/Recipient Name (print):		
Case Number:	Applicant/Recipient SSN:	Date of Birth:
2. Cash Assistance: I want		to
apply on my behalf, be interview	wed on my behalf, $\ \ \square$ receive copies of r	notices sent to me,
report changes for me and receive	information about my Cash Assistance.	
a. Applicant/Recipient Signature:		Date:
b. Authorized Representative Signature	e:	Date:
c. Authorized Representative Mailing Address:		
City:	State: Zip Code:	Phone Number:
3. Food Stamps: I want to		
☐ apply on my behalf, ☐ be interviewed on my behalf, ☐ receive and use Food Stamps on behalf of my household,		
receive copies of notices sent to me, report changes for me and receive information about my Food Stamps.		
a. Applicant/Recipient Signature:		Date:
b. Authorized Representative Signature:		Date:
c. Authorized Representative Mailing Address:		
City:	State: Zip Code:	Phone Number:
4. Health Coverage: I want to		
apply on my behalf, be interviewed on my behalf, receive copies of notices sent to me,		
report changes and remain my representative if my application is approved.		
a. Applicant/Recipient Signature:		Date:
b. Authorized Representative Signature:		Date:
c. Authorized Representative Mailing Address:		
City:	State: Zip Code:	Phone Number: